TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health HEB

Respondent Name
Travelers Casualty & Surety Co

MFDR Tracking Number
M4-17-0041-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
September 6, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "For the APC the allowable amount due totaled is $4,668.14. Based on their payment of $4,300.74 for the APC a supplemental payment is still due of $367.40 on the APC alone, at this time."

Amount in Dispute: $367.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the documentation and determined the Provider has been appropriately reimbursed the Outpatient Hospital Fee Schedule. The Carrier believes no additional reimbursement is due."

Response Submitted by: Travelers Casualty & Surety Co

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 30, 2015	Outpatient hospital services	$367.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in an outpatient setting.
3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers compensation jurisdictional fee schedule adjustment

- 243 – The charge for this procedure was not paid since the value of this procedure is included/bundled within the value of another procedure performed
- 863 – Reimbursement is based on the applicable reimbursement fee schedule
- 802 – Charge for this procedure exceeds the OPPS schedule allowance
- 797 – Service not paid under Medicare OPPS
- 170 – Reimbursement is based on the outpatient/inpatient fee schedule
- W3 – Additional payment made on appeal/reconsideration
- 193 – Original payment decision is being maintained. This claim processed properly the first time
- 1115 – We find the original review to be accurate and are unable to recommend any additional allowance
- 947 – Upheld no additional allowance has been recommended
- 974 – This procedure is included in the basic allowance of another procedure

Issues

1. What is the applicable rule that pertains to reimbursement?
2. How is the maximum allowable reimbursement calculated?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The requester seeks additional reimbursement in the amount of $367.40 for outpatient hospital services rendered on September 30, 2015.

   The requestor states, "…a supplemental payment is still due of $367.40 on the APC alone, at this time."

   The respondent states, "The Carrier has reviewed the documentation and determined the Provider has/been appropriately reimbursed the Outpatient Hospital Fee Schedule."

   The insurance carrier reduced the disputed services with reduction codes, P12 – "Workers compensation jurisdictional fee schedule adjustment," and 97 – "The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated."

   The Division finds that the outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

2. The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   The resources that define the components used to calculate the Medicare payment for OPPS are found below:

   - **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
     - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*

   - **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

- **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

28 Texas Administrative Code §134.403 (f) states in pertinent part,

> The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.
>
> > (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
> >
> > > (A) 200 percent;

The reimbursement calculations is as follows:

Procedure Code	APC	Status Indicator	Payment Rate	60% labor related	2016 Wage Index Adjustment for provider 0.9512	40% non-labor related	Payment	Maximum allowable reimbursement
29877	0041	T	$2,151.57	$2,151.57 X 60% = $1,290.94	$1,290.94 X 0.9512 = $1,227.94	$2,151.57 X 40% = $860.63	$1,227.94+ $860.63 = $2,088.57	$2,088.57 X 200% = $4,177.14
							Total	$4,177.14

The remaining services are classified as follows:

- Procedure code 97001 has status indicator A. This service is not paid under OPPS but rather the physicians' fee schedule found at www.cms.gov. The fee found for date of service September 30, 2015 for code 97001, is $73.06.

  The formula to calculate the maximum allowable reimbursement is (DWC Conversion Factor / Medicare Conversion Factor) x fee schedule allowable or (56.2/35.9335) x $73.06 = $114.26. This amount is recommended.

- Procedure code J7120 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 36415 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 80053 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code 88304 has status indicator Q1 denoting STVX-packaged codes; payment for these services is packaged into the payment for any other procedures with status indicators S, T, V, or X

performed on the same date. This code may be separately payable only if no other such procedures are reported for the same date.

- Procedure code 88311 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code G8978 has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims.
- Procedure code G8979 has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims.
- Procedure code G8980 has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims.
- Procedure code J1885 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2001 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2250 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2270 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2405 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2704 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J2765 has status indicator N denoting packaged items and services with no separate APC payment.
- Procedure code J3010 has status indicator N denoting packaged items and services with no separate APC payment.

3. The total allowable reimbursement for the services in dispute is $4,291.40. This amount less the amount previously paid by the insurance carrier of $4,300.74 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		October 18, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.